Department of Alcohol and Drug Programs

TESTIMONY OF KATHRYN P. JETT, DIRECTOR
FOR THE LITTLE HOOVER COMMISSION

9:00 A.M., May 23, 2002, State Capitol Room 437

Good morning! My name is Kathryn Jett, and I am the Director of the Department of Alcohol and Drug Programs (ADP). ADP is the primary state agency responsible for the comprehensive statewide alcohol and other drug system of care. Thank you for this opportunity to provide information and comments regarding alcohol and other drug abuse and treatment.

This morning I am going to discuss five key areas:

I. Brief History of ADP
II. Overview of the State System of Care
III. Summary of the Treatment System
IV. State's Vision for Treatment Programs
V. Strategic Direction to Improve the Treatment System

The Department is committed to maintaining an exemplary system of care for alcohol and drug prevention, treatment, and recovery. We have a long history of hard work and learning which has brought us to this point. I'd like to take a moment to briefly share some of this history with you.

I. Brief History of ADP

- Almost 50 years ago, responsibilities for alcohol programs were not located within a single state agency. The State Alcoholic Rehabilitation Commission, established in 1954, was the first to set a pattern for state agencies to make contractual arrangements with local alcohol clinics for services.

- In 1957, the California Department of Public Health, Division of Alcohol Rehabilitation, was created and eventually evolved to coordinate state efforts and funding of all public alcohol-related programs.

- When the 1967 "Summer of Love" catapulted recreational drug use into the media and the public eye, there was no cohesive public policy to address the rapidly expanding drug abuse problem. A patchwork of "alternative medicine" and peer provider clinics sprang up to meet the increasing need for crisis intervention and recovery.

- In 1971, the State Office of Narcotic and Drug Abuse Coordination was established in the Health and Welfare Agency Office. This office was charged with developing a statewide drug program policy. The name was changed from "Coordination" to "Abuse" in 1973 (SONDA). There was also the separate Office of Alcoholism within the Department of Health.

- The end result was that, in the early years, the state had two different departments responsible for providing alcohol and drug abuse leadership, developing policy and planning service delivery.

- In about 1977, SONDA was moved into the Department of Health to join the Division of Drug Abuse. The two organizations operated as the Substance Abuse Branch, combined but maintaining separate programs.

- In 1978, the State drug program was combined with the State alcohol program to create a new Department of Alcohol and Drug Abuse (SB 363). "Abuse" was later changed to "Programs." The full scope of ADP's administrative responsibilities and major programs are outlined within the Health and Safety Code, Section 11750-11999.25.

- During the early years, the new department was more focused on developing programs and modalities than it is today. At the same time, we were conducting research, learning quickly, establishing a treatment system, building treatment capacity, and consistently obtaining funding for the field.

- In the late 1980's and early 1990's, ADP moved out of research and development and into a more administrative role. The divisions of alcohol and drug services merged into a single program division focusing more on moving money to the field.

- Along with this shift in ADP's focus, local control began to drive the programmatic development of the alcohol and drug services system in the early to mid-1990's.

- Today, ADP operates from a science base. We have more solid research knowledge now than ever before about what works and where to allocate resources for better outcomes.

- A stigma still remains with the perception that alcohol and drug addiction is a moral weakness or criminal justice problem, not a public health issue. But today many studies have been completed which verify that addiction is a chronic, recurring health issue, a disease every bit as real as diabetes or heart disease.

- Alcoholism and drug addiction are chronic conditions that can be successfully prevented and treated. This research-based concept is shaping state treatment policy, especially regarding continuity of funding, and providing a full range of services from prevention through aftercare.

- Drug courts in California have been a strong partner with treatment programs since their inception. Since 1988, thirty-four counties have been operating drug court programs, pursuant to the Drug Court Partnership Act.

- In our March 2002 report to the Legislature we presented the results of the evaluation of this program. The Drug Court Partnership program demonstrated the cost effectiveness of drug courts through averted incarceration costs and participants payment of fees. Also, anecdotal information supports that those counties with established drug courts are more successfully implementing the Substance Abuse and Crime Prevention Act of 2000 (SACPA) programs.

- We also have the Substance Abuse and Crime Prevention Act of 2000 (Proposition 36) which represents a paradigm shift from incarceration to treatment and collaboration. This shift is having a great impact on our field.

- As Director of ADP, I am committed to providing leadership to the field, implementing science-based practices, and increasing our knowledge about addiction in order to improve our service delivery system.

I wanted to present this history of the evolution of California's alcohol and drug prevention and treatment system to give you perspective, and help you understand the great evolution and growth that has taken place within our field. "It is essential that treatment professionals and political and judicial decision-makers have an understanding of the causes and effects of substance abuse/addiction and their implications for treatment."[1] Without this intelligence and understanding, any resulting public policy and programmatic foundation created will be less than optimal.

II. Overview of the State System of Care

The Department of Alcohol and Drug Programs (ADP) is the designated single state agency responsible for the oversight of substance abuse treatment and prevention programs in California. With over 300 employees, the Department has programmatic expertise in the areas of prevention, treatment, recovery services and programs. The Department works in partnership with county governments, private and public agencies, organizations, groups, and individuals. ADP provides leadership and coordination in the planning, development, implementation, and

[1] Coyne, Thomas H. "Understanding Drug Abuse and Addiction: Psychopharmacology of Addiction and Its Impact on Treatment." Paper presented to Prop. 36 Statewide Conference, UC San Diego, California. May 14, 2001.

evaluation of a comprehensive statewide alcohol and other drug prevention, intervention, detoxification, treatment and recovery system.

The Department's vision is "Working together to foster healthy individuals and communities free of alcohol and other drug problems".

The Department's mission statement reads: "The Department leads and administers California's strategy to reduce alcohol and other drug problems by administering, developing and supporting effective prevention and treatment services and programs".

Our mission includes the responsibility for ensuring that Californians are healthy, contributing persons in communities free of alcohol and other drug related problems. To meet this responsibility, the Department performs the following functions:

1. A Service Delivery System – Design, maintain and continuously improve a statewide infrastructure for the delivery of community-based alcohol and other drug services. This is achieved through ongoing partnership with the above entities.

2. System Financing – Provide efficient and effective system of obtaining, allocating, administering and accounting for funds used in the alcohol and other drug system.

3. Quality Assurance – Ensure that providers of services to alcohol and other drug clients maintain basic program and physical plant standards, narcotic replacement therapy, residential treatment centers, and outpatient programs.

4. Alcohol and Other Drug Prevention – Maintain a highly visible prevention program designed to avert, reduce and eliminate alcohol and other drug related problems among California's children, youth and adult populations. The Department actively promotes mentoring as a prevention strategy and provides support to county alcohol and other drug programs to assist in this endeavor.

5. Information Technology – Develop an information infrastructure that supports the goals, strategies, and operations for the Department and its stakeholders.

The Department provides a comprehensive network of services for the general population and special target groups to assist individuals and their families impaired in social, psychological, and economic functioning resulting from alcohol and other drug abuse. Funds for services are provided from ADP to local government (counties) which plan and administer a system of services appropriate

to local needs. There is a focused attempt to match treatment services to client needs.

To promote enhancements within the field, ADP is implementing system improvements that will shape the future of the service delivery system. I will discuss these improvements more specifically later in the testimony.

As part of a discussion of the State's vision for treatment programs, it is important to understand how the State's treatment system operates. The next section is a brief discussion of this system.

III. Summary of the Treatment System

The California treatment system serves more than 359,500 clients annually, and ADP licenses, certifies, and monitors the effectiveness and efficiency of more than 1,980 treatment programs administered through county governments and private providers (projected from FY 2001-02 CADDS data, April 2002).

Community-based programs are the backbone of the system of care. In addition to the 1,980 licensed and certified programs, many other services function in the community. School-based prevention, youth mentoring, and neighborhood recovery services all have a role in the community system of care.

ADP also implements extensive prevention strategies and carries out special projects and programs designed to reduce the incidence of alcohol and other drug-related problems. Programs are designed for the general population and for specific target populations, such as pregnant and parenting women, junior high and high school youth, and the dually diagnosed.

ADP's publicly funded system of care is managed in partnership with each of the 58 county governments. The Health and Safety Code requires local government to designate an alcohol and drug administrator to coordinate local prevention and treatment services. This role provides each community with coordination and expertise in alcohol and other drug prevention and treatment services.

ADP allocates over $506 million in state and federal funds to local governments and contract providers and negotiates service contracts (this figure includes State General Fund, Substance Abuse.[2] Local governments and communities manage resources and needs by establishing a spending plan to meet their needs, comply with funding terms and conditions, and prioritize available resources.

The county alcohol and drug administrator and the local Board of Supervisors contract with community-based substance abuse providers to meet the local needs, priorities, and requirements for services. The alcohol and drug

[2] This figure is from ADP's proposed FY 2002-03 budget, and includes local assistance monies in the SGF, SAPT with set asides, Safe & Drug Free Schools, Parolee Services Network, SACPA, prevention, drug courts, and federal shares of Drug Medi-Cal.

administrator also collaborates with local agencies, schools, the faith community, and businesses to coordinate community alcohol and other drug prevention and treatment efforts.

We have come to this point through a few major policy changes over the past seven years, beginning with the Budget Act of 1995.

A. The System of Care Redesign

- The Budget Act of 1995 created the System of Care Redesign, with the goal of providing a quality integrated coordinated, seamless system of alcohol and other drug prevention, early intervention, and recovery/treatment services for families and communities. The project built in accountability to measure outcomes and societal costs and benefits related to alcohol and other drug treatment services.

- Fundamental to the System of Care Redesign was SB 2015, which directed ADP to test a comprehensive, client-centered system of care that is outcome-based and looks at societal costs of substance abuse. In response, ADP developed the California Treatment Outcome Project, in accordance with the federal TOPPS II grant protocol requirements.

B. The California Treatment Outcome Project Pilot

- The California Treatment Outcome Project is piloting an automated system to track client movement through county treatment systems and determine service outcomes in terms of alcohol and other drug abuse and other social service needs.

- Preliminary analysis of almost 5,000 clients, reveals the potential this valuable data has to offer in improving alcohol and other drug treatment policy and practice:

  When problem severity at treatment intake is compared with data collected at 3-month and 9-month post-admission follow-up, preliminary results indicate significant decreases in the following areas:

  - ✓ Medical needs requiring physician, emergency room visits, or hospital stays;
  - ✓ Psychiatric needs requiring psychiatric admission;
  - ✓ Alcohol and drug use;
  - ✓ Unemployment dropped by 30%; and
  - ✓ Similar results are found in criminal justice and non-criminal justice populations.

A report will be presented to the Legislature in January 2003.

C. The California Outcome Measurement System

One of the major Departmental efforts for achieving the vision is to create an outcome-based system of care that focuses on each client's individual needs and provides improved data and accountability. At the same time, changes in the business environment are requiring more accountability and efficient administration of resources. To promote similar improvements within the alcohol and other drug field, APD formed a policy advisory committee that recommended a system of improvements that will shape the future of California's service delivery system. The California Outcome Measurement System (Cal-OMS) will help ADP actualize the system of care vision and achieve long-range goals through the fine-tuning of a system of care.

D. Impact of the Substance Abuse and Crime Prevention Act of 2000 (Proposition 36) on the Treatment System

In November 2000, the Department was designated the lead State agency for implementing the Substance Abuse and Crime Prevention Act of 2000 (Proposition 36). The Act mandates treatment for nonviolent drug offenders, and is the most significant California State law change since "Three Strikes." It substantially changes both judicial processes and drug treatment systems.

The passage of the Act represents a paradigm shift from incarceration to treatment and collaboration. The Act affects how treatment is organized, managed and delivered. In response, the Department has developed a holistic approach that offers treatment provided by multi-disciplinary teams, and emphasizes collaboration vertically and horizontally between systems as the most important factor for success.

The Act is the product of a gradual change in public sentiment, provides a policy shift which reflects this change. It creates opportunities for new directions, and will help "scientifically" demonstrate the benefits of years of treatment and incarceration outcome research.

E. Licensing and Certification of Treatment

Residential facilities that provide nonmedical alcoholism or drug abuse recovery, treatment, or detoxification services to adults must be licensed by ADP. Health and safety concerns are the primary focus of this process. As of April 2001, there were 773 licensed facilities operating in the State (ADP Licensing and Certification Division data).

Approximately 62 percent of the licensed residential facilities are alcohol and other drug certified. Certification is voluntary for all programs, but is considered beneficial. Certification enhances service quality, and signifies that a program

meets minimal levels of service quality and is in substantial compliance with State program standards.

As of April 2002, there were 717 certified nonresidential programs (ADP Licensing and Certification Division data). Since ADP only identifies those programs which request certification, there are an undetermined number of these programs operating in the State.

F. The Need for Treatment

- The causes and consequences of drug use are many and varied. They affect families, schools, crime, violence, health, the economy, and the communities in which they occur.

- Alcohol and other drug-related problems permeate all aspects of our society and underlie much of the health and social costs in society. Those who use alcohol and drugs are in all systems, including education, social services, health services, and criminal justice.

- Alcohol and other drug abuse has no socio-economic barriers. Use and abuse cuts across all segments of the population, all income levels, all ages, genders, races and ethnicities.

- An estimated 1.5 million Californians a year – 6.6% of the state's population – need treatment (2002 UCLA study completed for ADP). [3]

- 1.4 million Californians reported past-year alcohol or other drug dependence in 2000 (California Household Substance Use Survey, February 1999).

- The estimated cost to society of alcohol and other drug abuse due to lost productivity, health care costs, prevention and treatment costs, losses due to crime and criminal justice costs is $32.7 billion a year (ADP projection based on 2000 NIDA/NIAAA study identifying $965 as the cost per person of alcohol and other drugs abuse across the U.S.). [4]

- Alcohol and other drug abuse is a main factor in chronic diseases, the spread of infectious diseases, hospital emergency room visits, newborn health problems, violence, and automobile fatalities.

[3] (This estimate is based on a study completed for ADP by UCLA for the federal State Treatment Needs Assessment Program (STNAP). Final Report to CSAT, "A State Treatment Demand and Needs Assessment: Alcohol and Other Drugs." State Department of Alcohol and Drug Programs, January 30, 2002.)

[4] Source: the Economic Cost of Alcohol and Drug Abuse in the U.S., 2000. National Institute on Drug Abuse & National Institute on Alcohol Abuse & Alcoholism.

G. The Treatment Population

Within the treatment population, the preferred drugs of abuse in order of use are alcohol, cigarettes, marijuana, cocaine, stimulants (including methamphetamines), inhalants, and hallucinogens. The highest rates of use and dependence are reported by the 18-25 age group (ADP CADDS data 7/1/99-6/30/00).

The latest treatment population data indicates that 64 percent of those admitted are male and 36 percent are female. Males are over represented in heroin admissions, alcohol, marijuana and inhalants. Females are over represented in methamphetamine, crack cocaine, PCP, and non-medical use of prescription drugs (ADP CADDS data 7/1/99-6/30/00).

Among those in treatment in 2000, younger clients (18-35 year olds) tended to enter treatment for methamphetamine problems. Clients entering treatment for heroin-related problems tended to be older (36 year olds and older). [5]

Of those entering treatment, 23 percent are employed full or part-time; 61 percent have at least a high school education; 8 percent are "dually diagnosed" (with a mental health problem), 21 percent are homeless; and 19 percent are Medi-Cal beneficiaries (ADP CADDS data 7/1/99-6/30/00). [6]

We also know that each year there are new trends in drugs being used and abused. These emerging trends and issues present continual resource and policy challenges for both the State and the treatment field. For example, lately we have been hearing a lot about club drugs. In the recent past, other issues, such as methamphetamine use and alcohol and drug use among certain populations (for example, the homeless and American Indians), have been prominent. It is important to remember that these issues are not solely associated with alcohol and drug use and abuse, but are woven into the fabric of larger societal problems which confront and challenge the resources and policies of a variety of state agencies.

Recent national and international developments, such as the terrorist attacks of September 11, 2001, may be adding to the alcohol and drug use problem as people try to cope with increased levels of stress and anxiety in their daily lives. Although there is little scientific evidence to support this, the anecdotal evidence is mounting, and this is an area we will continue to monitor at the State level.

[5] The original clinics were established to serve the Viet Nam era heroin addicts, and as that population ages so does the treatment population.

[6] CADDS Data of July 1, 1999 through June 30, 2000, ADP, October, 2000.

H. Treatment Service Gaps

The latest comprehensive data we have comes from a family of studies completed for the Department in early 2002 by UCLA under a CSAT contract. The studies found that:

- The estimated need for alcohol and other drug treatment in 1997 was approximately:
    - ✓ 1.5 million within the population age 12 and older – 6.6% of the population;
    - ✓ 789,000 among the arrestee population, age 18 years and older; and
    - ✓ 220,000 among youth 12-17.

- Rates of treatment need were considerably higher among arrestees (61%) and out-of-school youth (39%) than among household and in-school youth populations.

- Only a portion of those needing treatment can be considered likely to demand publicly funded treatment, since some people who need treatment would access services in the private sector, would not be ready or motivated to enter treatment, or would not access services because of other barriers. [7]

The studies also found that service availability varies by county, and this in turn affects each region throughout the State. Similarly, the need for treatment varies by county and by region. For example, at the regional level, estimates of treatment need range from a low of 5.4% in Los Angeles County to a high of 19.3% in the Northern Region of the state. This is mostly due to a shortage of facilities and availability of treatment services.

I. How the State Measures Treatment Accomplishments

We know that treatment is effective. Treatment has positive effects on the safety and health of individuals, their families and communities. Based on years of scientific research and clinical practice, the components of effective treatment are well known, and should include a combination of behavioral therapies and/or medications, be tailored to the many needs of clients, be accessible, be flexible enough to allow modifications in response to varying client needs, and be of adequate duration to be effective.

[7] State Treatment Needs Assessment Program (STNAP). Final Report to CSAT, "A State Treatment Demand and Needs Assessment: Alcohol and Other Drugs." State Department of Alcohol and Drug Programs, January 30, 2002.

California has been a consistent leader in the field of women's substance abuse and perinatal alcohol and other drug treatment. Some of the positive outcomes from the investment in perinatal treatment include drug-free deliveries, healthier babies, increased mother-infant bonding, less involvement with child welfare services, fewer children placed in foster care, and more and earlier family reunifications after foster care placement. A major (treatment) goal is to return the client to productive functioning. State and national studies have found that treatment reduces drug use by 40-60 percent; reduces crime by 40-50 percent; and increases employment prospects by 40 percent. [8]

Length of treatment is associated with treatment success, as supported by both State and national level studies. The benefits accumulated from changes in behavior during treatment appear to be as important as the benefits from long-run changes in behavior that treatment may bring about.

Treatment also reduces health care costs associated with alcohol and other drug abuse. Because drug abusers typically receive poor preventative health care, they are substantively over-represented in hospital settings-especially in emergency rooms where health care is most expensive.

ADP's policies support the vision of "Working together to foster healthy individuals and communities free of alcohol and other drug problems."

IV. State's Vision for Treatment Programs

The Governor and the Legislature have provided leadership for the State by recognizing that substance use has no boundaries and by continuing to invest in treatment and promote linkages between departments and systems to address this problem. However, there are still 6,300 people statewide on waiting lists for treatment (the Drug and Alcohol Treatment Access Report – DATAR; January 2002. Both alcohol and drug programs report to this ADP system monthly on treatment capacity and waiting lists).

Efforts need to continue in order to provide opportunities for those in the service system to work together to make a positive difference in the lives of the people that we serve. The State's treatment vision has been reviewed in this testimony, and this vision encompasses the following key elements:

- *Science-based*
- *Quality-focused*
- *Comprehensive service delivery system*
- *Flexible and open to change*

[8] Coyne, Thomas H. "Understanding Drug Abuse and Addiction: Psychopharmacology of Addiction and Its Impact on Treatment." Paper presented to Prop. 36 Statewide Conference, UC San Diego, California. May 14, 2001.

- *Operates in partnership with counties*
- *Encourages and values input from stakeholders*
- *Matches client needs to treatment resources*
- *Incorporates standards and automation*

In addition, the federal government is mandating that states must achieve certain accountability goals and objectives, starting in 2004. Although we do not yet know the mandate specifics, we are aware that this is coming and are planning accordingly.

V. Strategic Direction to Improve the Treatment System

The past year has been a dynamic time of change for the Department. The challenges of implementing the Substance Abuse and Crime Prevention Act of 2000, significant changes in staffing and leadership within ADP, resource uncertainty created by the energy crisis, and the sharp economic downturn in the State, reinforced the need for ADP to clarify its mission and vision and to carefully plan ahead. We are in the process of developing a strategic plan which will focus on four broad themes:

- Prevention and Treatment Systems Enhancement
- Professionalization of Treatment and Prevention Services
- Financing
- Internal Capacity Building

There are significant opportunities to improve the delivery of services, which are currently characterized by limited coordination, outdated infrastructure, and inconsistent application of sound business, prevention and treatment principles. Many of the programs that provide services are perceived as having a low level of professionalism, and may lack the necessary competencies to be effective providers. We will continue to increase our ability to address emerging needs, trends and issues regarding the professionalism and competencies of the field.

The Department's management and staff are dedicated to providing high quality customer service. Our strategic plan will begin implementation in July 2002. We recognize the significant opportunities ahead of us to enhance service delivery throughout California, and we are up to the challenge of meeting this need. As a result of our strategic planning process, ADP is eager to begin from a fresh starting point, to initiate the changes needed to improve California's alcohol and drug treatment system for all citizens.

This concludes my testimony today. I want to thank you for your attention and welcome any questions you might have.